



The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 107
 600 Washington Street – 7th Floor, Boston, Massachusetts 02111
 Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
<http://www.mass.gov/dia>

DIA Board #
(If Known):

INSURER'S NOTIFICATION OF ACCEPTANCE, RESUMPTION
OR TERMINATION OR MODIFICATION OF WEEKLY COMPENSATION

CHECK ONE BOX: ☐ **ACCEPTANCE** ☐ **RESUMPTION** ☐ **TERMINATION** ☐ **MODIFICATION**

USE FORM 106 AS NOTICE TO TERMINATE OR MODIFY WEEKLY PAYMENTS BEING MADE WITHOUT PREJUDICE

UNDER M.G.L., CHAPTER 152 §8(1). *Please Print or Type.*

I N S U R E R	1. Insurance Carrier's Name and Address:		2. Self-insured?: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes Please Give Self-insurer Number:																			
	3. Name & Address of Insurer's Attorney:		4. Telephone Number of Insurer's Attorney:																			
	5. Claim Representative's Name:		6. Claim Representative's Tel. Number & Ext.:																			
	7. Insurer's Case File Number:		8. Did Insurer Receive First Report of Injury (Form 101); <input type="checkbox"/> Yes <input type="checkbox"/> No - If Yes - Date Received (mm/dd/yyyy):																			
E M P L O Y E E	9. Employee's Name (Last, First, MI):		10. Employee's Social Security Number*:																			
	11. Employee's Address (No. and Street, City, State, Zip Code):		12. Date of Birth (mm/dd/yyyy):																			
			13. Date of Injury (mm/dd/yyyy):																			
	14. First Day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):		15. Fifth Day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):																			
	16. Employer's Name & Address (No. and Street, City, State, Zip Code):		17. Employee's Average Weekly Wage: \$ _____ <input type="checkbox"/> Actual <input type="checkbox"/> Estimated																			
	18. Employee Returned to Work: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes - Date of Return (mm/dd/yyyy):		19. Date of Resumption, Modification or Termination (mm/dd/yyyy):																			
B E N E F I T S	20. <input type="checkbox"/> This is a Notice of Initial Acceptance of a Claim (ATTACH FORM 113). <input type="checkbox"/> This is a Resumption/Modification of Payment of a Case Previously Accepted. <input type="checkbox"/> This is a Resumption of Payment of a Case within the Payment Without Prejudice Period. <input type="checkbox"/> This is a Resumption/Modification of Payment under §30G.																					
	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Type of Compensation Resumed or Modified</th> <th style="text-align: left; border-bottom: 1px solid black;">Former Weekly Compensation Rate</th> <th style="text-align: left; border-bottom: 1px solid black;">Resumed or Modified Weekly Compensation Rate</th> </tr> </thead> <tbody> <tr> <td>A. <input type="checkbox"/> Temporary, Total Incapacity (§34)</td> <td>\$ _____</td> <td>\$ _____</td> </tr> <tr> <td>B. <input type="checkbox"/> Permanent & Total Incapacity (§34A)</td> <td>\$ _____</td> <td>\$ _____</td> </tr> <tr> <td>C. <input type="checkbox"/> Partial Incapacity (§35)</td> <td>\$ _____</td> <td>\$ _____</td> </tr> <tr> <td>D. <input type="checkbox"/> Dependency Coverage (§35A)</td> <td>\$ _____</td> <td>\$ _____</td> </tr> <tr> <td>E. <input type="checkbox"/> Survivor's Benefits (§31)</td> <td>\$ _____</td> <td>\$ _____</td> </tr> </tbody> </table>				Type of Compensation Resumed or Modified	Former Weekly Compensation Rate	Resumed or Modified Weekly Compensation Rate	A. <input type="checkbox"/> Temporary, Total Incapacity (§34)	\$ _____	\$ _____	B. <input type="checkbox"/> Permanent & Total Incapacity (§34A)	\$ _____	\$ _____	C. <input type="checkbox"/> Partial Incapacity (§35)	\$ _____	\$ _____	D. <input type="checkbox"/> Dependency Coverage (§35A)	\$ _____	\$ _____	E. <input type="checkbox"/> Survivor's Benefits (§31)	\$ _____	\$ _____
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	21. If the Insurer is Terminating or Suspending Payment of Weekly Benefits without the Assent of the Employee or the Dept. of Industrial Accidents, set out the Applicable Statutory Section and Factual Basis Therefore (continue on the reverse side if needed): _____ _____ _____																					
	22. If the Insurer is Terminating or Modifying with the Assent of the Compensation Recipient, the Recipient's Signature is Required. Signature of Recipient: _____																					
23. Insurer's Signature :		24. Date Prepared (mm/dd/yyyy):																				

This image shows a full page of blank, lined paper. It features approximately 20 horizontal black lines spaced evenly apart, typical of notebook paper. The lines extend across the entire width of the page, leaving small margins at the top and bottom. There are no vertical lines or other markings present.